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**Advisory Statement for Non-Melanoma Skin Cancer Care
During the COVID-19 Pandemic**

(Contributions from Dana Farber/Brigham and Women's Cancer Center, Case Comprehensive Cancer Center/University Hospitals Seidman Cancer Center and Cleveland Clinic Taussig Cancer Institute, City of Hope National Medical Center, Fred Hutchinson Cancer Research Center/Seattle Cancer Care Alliance, Mayo Clinic Cancer Center, Memorial Sloan Kettering Cancer Center, Moffitt Cancer Center, O'Neal Comprehensive Cancer Center at UAB, Sidney Kimmel Comprehensive Cancer Center at Johns Hopkins, Roswell Park Cancer Institute, Stanford Cancer Institute, The Ohio State University Comprehensive Cancer Center - James Cancer Hospital and Solove Research Institute, UCSF Helen Diller Family Comprehensive Cancer Center, University of Michigan Rogel Cancer Center, University of Texas MD Anderson Cancer Center, University of Wisconsin Carbone Cancer Center, and Vanderbilt-Ingram Cancer Center)

The advisory should be interpreted in the context of practitioners' local situations which may differ geographically and evolve over time.

General statements:

Multi-disciplinary teleconferences should be utilized whenever possible to develop care plans for Merkel cell carcinoma and other high-risk non-melanoma skin cancers (NMSCs) requiring treatment beyond office-based excision of local disease.

Such complex decisions should be made on a case-by-case basis based on individual patient factors and available resources.

Triage of concerns of new tumors should be conducted via teleconference between physician and patient including video or photographic evaluation of the lesion when feasible.

Consider repeated teleconference and/or photographic follow-up of small lesions suspected of being NMSC, reserving biopsy for growing or highly concerning lesions. For small lesions undergoing biopsy (eg, suspected melanoma or Merkel cell carcinoma), obtain photographs with landmarks, use tattoos, or have the patient re-mark the site daily to facilitate accurate site localization in case excision is delayed due to limited resources.

Physicians are encouraged to work with local authorities to comply with institutional and local guidelines, and be prepared to suspend excisional surgery if insufficient space, equipment or personnel are available to proceed safely.

Patients who develop perioperative COVID-19 infections may be subject to unanticipated post-surgical complications. Self-quarantine before and after surgery may reduce such risks. Review plan of care (contact PCP, local ER, etc.) with patients, in advance, should they develop signs and symptoms of post-surgical respiratory illness.

Merkel cell carcinoma:

- Merkel cell carcinoma excisions should NOT generally be deferred during the COVID 19 pandemic as delay may lead to disease progression including metastasis. Exceptions may be considered for tumors <1cm in the elderly or frail.
- Office-based excisions using wide local excision (WLE) with standard margins or Mohs surgery may be undertaken with deferral of sentinel lymph node biopsy (SLNB) if operating rooms are unavailable. To facilitate possible later SLNB, excisions should be allowed to granulate, or closed primarily via cerclage or linear closure without undermining.
- Patients who present with clinical stage III disease should have their treatment discussed in a multidisciplinary format. The options include definitive resection of the primary with complete lymphadenectomy versus off-label use of immunotherapy. The decision should be based on the patient's medical comorbidities (risk of COVID-19 sequelae), degree of tumor burden, and scarcity of hospital resources.
- To minimize visits and COVID-19 transmission risk, utilization of hypofractionation (eg, 1-3 fraction regimens; see PDFs on this site) or 40 Gy over 10 treatments of 4 Gy/fx may be considered.

Other NMSCs:

Excision of NMSC (excluding Merkel cell carcinoma discussed above) including basal and squamous cell carcinoma, dermatofibrosarcoma protuberans (DFSP), and rare tumors should generally be postponed during the COVID-19 pandemic. However, a NMSC may be considered for excision if it poses a risk of metastasis or debilitating progression within 3 months as estimated by the physician. Such estimations of risks posed by the tumor should be weighed against risks of the patient contracting COVID-19 infection or asymptotically transmitting COVID-19 to healthcare workers during care.

Adjuvant therapy after surgical clearance of local disease should generally not be undertaken given the multiple visits required and possible increased risk of COVID-19 transmission. Exceptions may include extensive or multifocal invasion of large caliber nerves, clinical trials (where operational), and AJCC Cancer Staging Manual, Eighth Edition N2 disease (eg, multiple nodes involved, extranodal extension, a nodal disease focus over 3cm).

Use of definitive radiation versus cemiplimab for unresectable disease should be determined on a case-by-case basis via multi-disciplinary discussion.

As COVID-19 infections decline:

NMSC excisions and other care may resume once COVID-19 infection rates are low. Consult local and institutional advisories to determine when it is considered safe to resume ambulatory care in your area. A 3-minute video is available with suggestions for how to minimize COVID-19 transmission risk during ambulatory care (<https://youtu.be/oM0BVuzwtP4>).

Methods to minimize spread of COVID-19 during office-based excisional surgery:

- Screen patients and staff for fever, cough and other COVID-19 symptoms as per local guidance and prior to each entry into office/care facility.
- Discourage patients from touching elevator buttons, pens, counter-tops or other office/care facility objects until they enter the procedure room.
- Allow no more than one person to accompany patients to appointments.
- Allow 6 feet of space between each patient in the waiting room at any given time. Cleanse waiting room chairs and surfaces with antiviral disinfectant after each person departs.
- Keep patients in procedure rooms after checking in.
- Have patients provide their own food or snacks.
- Clean pens, mirrors, and other objects patients must touch with alcohol or soap and water for 20 seconds immediately before and after their contact with each item. Staff should wear gloves when handling such items with patients.
- Ensure the minimal number of staff needed for care are present (eg, 1 surgeon, 1 assistant).
- Ensure doctors and nurses wear masks and gloves for all patient contact. Masks should be worn continuously in clinical areas and when coworkers are within 6 feet of each other.
- For facial cases requiring prolonged excision or reconstruction, especially those on nose or lips, practitioners may be at elevated risk of contracting or transmitting COVID-19 infection. Use properly-fitted N95 masks and face shields to protect eyes and mask. N95 masks may be reused by the same person and stored in paper bags when not in use. However, it is unknown how many re-use episodes are possible before mask fit and filtration become impaired. This site summarizes emerging medical literature regarding N95 mask re-use and decontamination techniques: [n95decon.org](https://www.n95decon.org)
- Use dissolving sutures to avoid a return visit.
- Cleanse procedure rooms thoroughly including countertops, beds, chairs, keyboards, phones, light switches/handles, doorknobs, etc. with antiviral disinfectant after each patient.
- Manage post-operative questions and complications via telemedicine (video or phone with digital photo review) as feasible.